Aetna Health of California Inc.
PO BOX 14079
LEXINGTON, KY 40512-4079

Statement date: June 22, 2026

Member: STEVEN JONES
Member ID: W278286922
Group #: 0187677-10-202 A EACYCR
Group name: COUNTY OF SAN MATEO

QUESTIONS? Contact us at aetna.com
1-833-576-2494
Or write to the address shown above.

STEVEN JONES
702 FARLEY ST
MOUNTAIN VIEW CA 94043

Explanation of Benefits (EOB) - This is not a bill

Your Explanation of Benefits (EOB) helps you understand what happened with your recent health care claim. It shows the amount billed by your provider, your member rate and cost share, and what your plan paid along with the savings you received. Take a moment to review your EOB and make sure everything looks correct. If you owe anything, you'll receive a bill directly from your doctor or health care provider; not from us. For convenience, you can change your delivery preferences anytime and easily view, print, or download your EOBs online.

Track your health care costs

Going to a provider in the network saves you money. That's because we have arranged discounted rates with these providers. To find a doctor or other health care professional, go to **www.aetna.com**.

Amount you have left to meet deductible

To see your latest deductible totals, look for "**Your benefit balances**" toward the end of this statement. It shows any amounts remaining for this plan year.

Your payment summary

		Plan's share			Your share
Patient	**Provider**	**Amount**	**Sent to**	**Send date**	**Amount**
Steven (self)		$0.00			$30.00
Total:		$0.00			**$30.00**

A guide to key terms

	Term	This means	Your totals
	Amount billed:	The amount your provider charged for services.	**$330.00**
	Member rate/ Allowed amount:	This is the health plan covered amount which may reflect a health plan discount. This may be referred to as the allowed amount or negotiated rate.	**$153.80**
!	**Pending or not payable:**	Charges that are either not covered or need more review by us. Read 'Your Claim Remarks' to learn more.	**$153.80**
	Deductible:	A cost share amount you pay for covered services before your plan starts to pay.	**$0.00**
	Coinsurance:	When you pay part of the bill and we pay part of the bill. It is a cost share out-of-pocket amount.	**$0.00**

Continued on next page

Term	This means	Your totals
Copay:	The fixed cost share amount you pay when you visit a doctor or health care provider.	**$30.00**
Your share:	The amount you're responsible for after your plan paid its share. You may have already paid your provider.	

Your claims up close

Claim for Steven (self)

Claim ID: EYPDVJHP400 Received on 6/20/26	**Amount billed**	**Member rate**	**Pending or not payable (Remarks)**	**Applied to deductible**	**Your copay**	**Amount remaining**	**Plan's share**	**Your coinsurance**	**Your share C+D+E+H=I**
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
OFFICE VISIT 99202 on **6/9/26**	120.00	77.00	62.00 (1)		15.00	62.00	62.00 (100%)		15.00
CHIROPRACTIC MANIPULATION 98943 on **6/9/26**	15.00		15.00 (1)			15.00	15.00 (100%)		
CHIROPRACTIC MANIPULATION 98940 on **6/9/26**	70.00	24.00	24.00 (1)			24.00	24.00 (100%)		
ELECTRIC STIMULATION THERAPY 97014 on **6/9/26**	20.00	14.40	14.40 (1)			14.40	14.40 (100%)		
Refer to Remarks Section			(2)						
Totals:	225.00	115.40	115.40	0.00	15.00	115.40	115.40	0.00	**$15.00**

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Claim for Steven (self)

Claim ID: EYY2VJHQF00 Received on 6/20/26	**Amount billed**	**Member rate**	**Pending or not payable (Remarks)**	**Applied to deductible**	**Your copay**	**Amount remaining**	**Plan's share**	**Your coinsurance**	**Your share C+D+E+H=I**
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
CHIROPRACTIC MANIPULATION 98943 on **6/16/26**	15.00		(1)		15.00				15.00
CHIROPRACTIC MANIPULATION 98940 on **6/16/26**	70.00	24.00	24.00 (1)			24.00	24.00 (100%)		
ELECTRIC STIMULATION THERAPY 97014 on **6/16/26**	20.00	14.40	14.40 (1)			14.40	14.40 (100%)		
Refer to Remarks Section			(2)						
Totals:	105.00	38.40	38.40	0.00	15.00	38.40	38.40	0.00	**$15.00**

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Your Claim Remarks

General Remarks:

(1) You do not owe this. Your doctor's contract with us includes a fixed pre-payment for certain services. This is one of those services, so no separate payment was made. [U12]

(2) Your provider may have sent diagnosis codes with your claim. You may obtain these codes and their meanings by contacting us at the number listed at the top of the first page. We will also provide your treatment codes and their meanings, if they do not appear on this statement. If you have questions about your diagnosis or your treatment, please contact your provider. [H63]

Your benefit balances to date for 1/1/26 to 12/31/26

Individual Balances	Annual limit	Amount used	Amount remaining
Steven (self)			
Medical In Network Out of Pocket Maximum	$1,000.00	$105.00	$895.00

Family Balances	Annual limit	Amount used	Amount remaining
Medical In Network Out of Pocket Maximum	$3,000.00	$105.00	$2,895.00

A complete list of your benefit balances and plan details can be found on your secure member website.

Access your benefits anytime!

Register or log into your member website today. When you're there, you can:

- View claims, EOB statements, and letters
- Find care and providers
- Track spending and deductibles
- Switch to paperless statements and so much more

Just scan the QR code to the left with your mobile phone to get started.

We don't discriminate on the basis of race, color, national origin, age, disability or sex (consistent with 45 CFR § 92.101(a)(2)). We also don't exclude people or treat them less favorably because of race, color, national origin, age, disability or sex. Visit Aetna.com/legal-notices/nondiscrimination-notice.html to view our Notice of Nondiscrimination. If you need language help and supportive aids free of charge, go to: Aetna.com/individuals-families/information-in-other-languages.html. Need a copy of this notice? Just call the phone number on your ID card.

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

More Information

Do you have questions? Call us free of charge at the toll-free number on the first page of this statement or on your member ID card.

Appeals

Please send your written appeal along with a copy of this entire EOB to this address:

Appeals Resolution Team
PO BOX 14032
Lexington, KY 40512-4032

You are entitled to a review (appeal) of this benefit determination if you have questions or do not agree.

To obtain a review, you or your authorized representative should call our Member Services Department using the telephone number displayed on the member ID card or submit a request in writing to the address shown above. Your request should include the group name (e.g., your employer), your name, member ID, address and date of birth and other identifying information shown on this notice, and any comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim. You may also request (free of charge) documents relevant to your claim. Verbal or written requests for review of the adverse determination must be communicated, mailed or delivered within 180 days following receipt of this explanation or such longer period as may be specified in your plan brochure or Summary Plan Description.

If your plan provides for a single appeal, notice of the final determination will be sent within 60 days following receipt of your request unless otherwise required by state law.

If your plan provides for two appeals, notice of a determination will be sent within 30 days following receipt of your request unless otherwise required by state law. If you do not agree with such determination, you have the right to file a second request for review.

Please review your plan documents or contact your plan administrator to determine the appeals process available to you.

If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 888-466-2219 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number 888-466-2219 and a TYY line (877-688-9891) for the hearing and speech impaired. The department's Internet Web site (www.HealthHelp.ca.gov) has complaint forms, IMR application forms and instructions online.

In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov, or by calling the department's consumer information line at 800-927-4357. You may also obtain a copy of this law and these regulations free of charge from this insurer.

What happens next
If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Your privacy
Your health information is confidential. Any information you give us will be kept private. When contacting us about this notice or for help with other questions, please be prepared to provide your member name, member ID, and date of birth.

Prevent fraud
If you suspect fraud or abuse involving these services or would like to report other healthcare fraud-related issues, please call the toll-free hotline at 1-800-338-6361 or e-mail us at aetnasiu@aetna.com.

Resources available to help you
Need help understanding this notice or our decision? **Call us free of charge at the toll-free number on your medical ID card.** There are also other resources available to help you. Most plans are now subject to health care reform law. Call us or ask your employer if your plan is subject to the law. If it is, you can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) for help, if your health plan is provided by your employer. In addition, a Consumer Assistance Program may be able to assist you. You may also contact the Department of Insurance.

California Department of Managed Health Care, 980 9th Street, Suite #500, Sacramento, CA 95814-2725
Tel: 888-466-2219 (Toll-free), TDD: 877-688-9891, Fax: 916-255-5241, Email: helpline@dmhc.ca.gov, Web: www.dmhc.ca.gov

California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower
Los Angeles, CA 90013, Tel: 800-927-Help (4357), TTY: 800-482-4833, Web: www.insurance.ca.gov

TTY:711

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Armenian	Ձեր նախընտրած լեզվով ավելար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հեռախոսահամարով
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน